TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Monzer H. Yazji, M.D.

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-16-1995-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 15, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**Rule 134.202 (6) (C) (iii)** says that an examining doctor, other than the treating doctor shall bill using the 'Work Related or medical disability **examination,** other than the treating physician…', CPT code. Reimbursement shall be **$350.00.**

Rule 134.202 (6) (D) (iii) says for musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. **(II) (-b-)** If full physical examination, with range of motion, is performed: **(-1-) $300.00** for the first musculoskeletal body area."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's documentation clearly indicates that the injured worker was not at MMI… Per Rule 134.204 (j) (2) (A), if MMI has not been reached, the provider should bill using the 'NM' modifier and the MMI portion of the examination shall be billed and reimbursed per 134.204 (j) (3) (C) which indicates reimbursement is $350.00."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 20, 2015	Designated Doctor Examination	$800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §130.1 sets out the procedures for certification of maximum medical

improvement (MMI) and impairment rating (IR).

3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 151 – Payment adjusted because the payer deems the information submitted does not support this many services.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Note: "Per Rule 134.204 (j)(2)(A) If the examining doctor, other than the treating doctor, determines MMI has not been reached. The MMI evaluation portion of the examination shall be billed and reimbursed.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – Additional payment made on appeal/reconsideration.
   - Note: "Rule 134.804 (a) Services reviewed for reconsideration. Additional payment made or service adjustment amount may be zero."
   - Note: "Maintaining original audit, per rule 134.204 if MMI has not been reached then provider shall bill NM modifier and only the MMI portion shall be billed and reimbursed."

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(2)(A),

   > If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

   Paragraph (3) states, "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that the requestor performed an evaluation of MMI and found that the injured employee was not at MMI. Therefore, the correct MAR for this examination is $350.00.

   28 Texas Administrative Code §130.1(b)(2) states,

   > MMI must be certified before an impairment rating is assigned and the impairment rating must be assigned for the injured employee's condition on the date of MMI. An impairment rating is invalid if it is based on the injured employee's condition on a date that is not the MMI date. An impairment rating and the corresponding MMI date must be included in the Report of Medical Evaluation to be valid.

   Review of submitted documentation supports that no IR was assigned. Therefore, no reimbursement is due for this examination.

2. The total MAR for the disputed services is $350.00. The insurance carrier paid $350.00. The requestor is not entitled to additional reimbursement for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	April 20, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.